Autopsy of the Medical record

By the end of this session the ID/D nurse will
- be able to review a medical record
- develop a health summary
- communicate to health care professions the entire picture of an individuals health.
- How to obtain the entire medical records
- development of a written nursing consultation report
- Develop recommendation and how to share with appropriate members of the team

The autopsy of the medical record

The goal for today is:

To have a better understanding how dissecting and organizing the medical health concerns that are mentioned in a medical records can produce optimal wellness.

Obtaining medical records

- Release of record
  - HIPAA:
  - Who can consent to release medical records:
  - Individual if presumed competent
  - Parent if individual is under 18 years of age
  - Guardian
  - Health care proxy only if invoked by doctor or the court

The Medical record can take on many forms

Historical information
Eligibility documents
Notes from interviews with individual family and care givers
Doctor's visit notes
ER and Hospital Admission Records
Nursing Rehab notes
Old and current ISP's (individual service plans)
Pharmacy Records of prescriptions

Where to obtain records

- PCP
- DDS/ GOVERNMENT ELIGIBILITY DOCUMENTS
- FAMILY
- HOSPITALS
- SPECIALISTS
- PHARMACIES
- ISP'S
- IEP'S

What forms to use

- Generic Form
- Hospital Release
- Medical records release
- Signing out a Government record

Autopsy :

- A detailed critical analysis of an individual's medical record.
  - Including History of medical assessments, medications, consults
  - Current reports of health issues
  - Interview of family members who might have contributions to the medical history of an individual.

GOAL: a comprehensive collection of all health issues old and new
GOAL: production of a chronological health summary
GOAL: development of a nursing assessment of health issues to be shared with individual's team members for consideration.

The medical record

- Start at the beginning.
- Do not assume that because the report is not a medical report that it would not have any useful information regarding an individuals health.
- remember to note any family history
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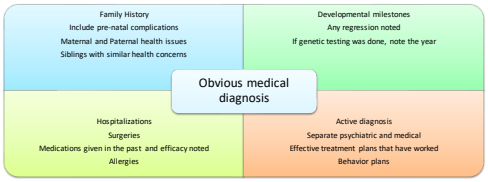
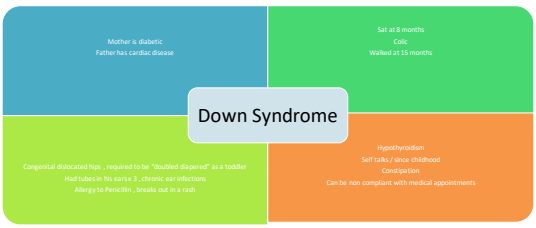
Breaking down the record into sections as you read.

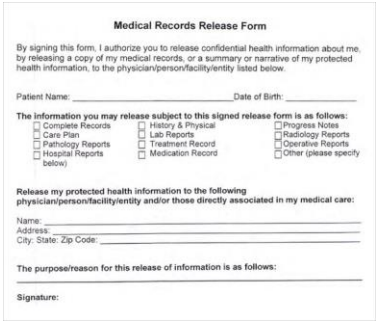


Example CHRIS .....



The break down into systems

- Start at the top of the head and work your way down to the feet.
- Separate into body system.



Medical Records Release Form

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

Patient Name: _____ Date of Birth: _____

The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ Care Plan
- ☐ Pathology Reports
- ☐ Hospital Reports
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Treatment Record
- ☐ Medication Record
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Other (please specify below)

Release my protected health information to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name: _____
Address: _____
City: State: Zip Code: _____

The purpose/reason for this release of information is as follows:

_____

Signature:

Development or the chronological summary

Development of the nursing assessment and recommendation

Case study one: Gerard

Case Studies two:

Case study three